

To be completed by parent/guardian for each child and submitted to the school annually.

**MEDICAL AND EMERGENCY NOTIFICATION INFORMATION
AUTHORIZATION FOR MEDICAL TREATMENT**

ST. PATRICK SCHOOL

SCHOOL YEAR: 2011-2012

STUDENT NAME	DATE OF BIRTH	GRADE	LIST MEDICAL ALLERGIES and/or SIGNIFICANT MEDICAL HISTORY

PLEASE PRINT

Parent/Guardian _____ Parent/Guardian _____

Home Phone: _() _____ Home Phone: _() _____

Work Phone :_() _____ Work Phone :_() _____

Cell Phone: _() _____ Cell Phone: _() _____

Name of Student's Physician _____

Physician's Phone # _____

Address: _____ City _____ State _____

Medical Insurance Provider _____ Policy/Insurance # _____

EMERGENCY CONTACTS IN CASE PARENT/GUARDIAN CANNOT BE REACHED:

Name: _____ Relationship to Student: _____

Phone 1 () _____ Phone 2 () _____

Name: _____ Relationship to Student: _____

Phone 1 () _____ Phone 2 () _____

MEDICAL RELEASE

In the event that the undersigned, or my/our authorized physician, cannot be reached and in the judgment of the School Principal or his/her authorized staff member, there is a necessity for immediate examination and/or treatment of my/our child, I/we hereby request and authorize any of the aforesaid personnel to obtain for my/our child such medical services as are deemed necessary. I/We agree to assume the financial responsibility for any diagnosis/treatment and/or for medication deemed necessary.

Parent/Guardian Signature

Date: _____

Parent/Guardian Signature

Date: _____

THIS FORM WILL ACOMPANY STUDENTS ON FIELD TRIPS. IT IS THE RESPONSIBILITY OF THE PARENT/GUARDIAN TO UPDATE EMERGENCY INFORMATION AS NECESSARY.